STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445343	A. BUILDING _____ B. WING _____	02/12/2014

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BRIDGE AT SOUTH PITTSBURG, THE	201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380

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F 000	INITIAL COMMENTS A recertification survey and complaint investigation #32451, #32770, and #33267, were completed on February 12, 2014, at The Bridge at South Pittsburgh. No deficiencies were cited related to the complaints under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	**Disclaimer:** The Bridge at South Pittsburg does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil of criminal claim, action or proceedings. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop a care plan to address depression for one resident (#34) of thirty-six residents reviewed.	F 279	**F279 Develop Comprehensive Care Plans**	03/16/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Donna Adams / Administrator | 3/7/2014

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop a care plan to address depression for one resident (#34) of thirty-six residents reviewed.	F 279	**F279 Develop Comprehensive Care Plans**	03/16/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 The findings included: Resident #34 was admitted to the facility on August 3, 2013, with diagnoses which included: Diabetes Type II, Dementia with Behavior, Chronic Kidney Disease Stage II, Abdominal Mass Left Upper Quadrant, Alzheimer's Disease, Senile Delusion, Persistent Insomnia and Generalized Anxiety Disorder. Medical record review of a Physician's Order dated December 4, 2013, revealed the resident was prescribed Celexa (an antidepressant drug) 20mg po (by mouth) q (every) am (morning). Medical record review of a Nurse's Notes dated December 4, 2013, revealed ..."received order to start Celexa 20 mg (miligrams) po q am." Medical record review of the care plan dated February 6, 2013, revealed the resident was not care planned for depression and no nursing interventions related to depression were present. Medical record review of the Nurse Practioner Behavioral Medicine Progress note dated January 15, 2014, revealed the resident received follow up for management of depression. Continued review revealed the resident had a clinical diagnosis of depression. Interview with the Regional Nurse Consultant on February 11, 2013, at 10:48 a.m., in the copier room of the Business office, confirmed the facility had failed to develop a care plan for depression for resident #34.	F 279	The resident has the right to be provided a comprehensive care plan that includes measureable objectives and interventions to meet a residents medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. **Residents Affected:** Resident #32 care plan was developed MDS Coordinator on 2/12/2014 to include clinical diagnosis of depression. **Residents Potentially Affected:** All residents have the potential to be affected by this cited practice related to depression. MDS coordinator will review residents with depression to ensure care plan reflects current diagnosis by 3/16/2014. Care plans will be updated as indicated. **Systemic Measures:** SDC/designee will educate by March 16, 2014. MDS personnel on updating care plans on residents with depression. The MDS Coordinator/designee will review 100% of care plans of residents with depression diagnosis weekly x 4 weeks then 25% x 2 months based on MDS schedule. Any concerns will be addressed with the MDS office and care plan immediately updated. **Monitoring Measures:** Any identified concerns related to depression diagnosis not reflected on the care plan will be corrected immediately and reported to the administrator. Concerns will be addressed in monthly QA x 3 months for recommendations and further follow-up as indicated.	
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=D	Continued From page 2 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to follow physician's orders for one resident (#179) of thirty-six residents reviewed. The findings included: Resident #179 was admitted to the facility on December 7, 2013, with diagnoses including: Cellulitis of Bilateral Legs, Lymphedema of Bilateral Legs, Morbid Obesity, Hypertension, Venous Stasis, Dermatitis, and Congestive Heart Failure. Observation on February 11, 2014, at 8:26 a.m., at the bedside of resident #179 revealed LPN (Licensed Practical Nurse) #1 flushed the resident's PICC (venous access catheter) line with five cc's (cubic centimeters) of normal saline solution from a ten cc syringe prior to administration of an intravenous antibiotic. Medical record review of a physician's order dated February 4, 2014, revealed the PICC line was to be flushed with ten cc's of normal saline solution every shift, before and after each use, and as needed. Interview with LPN #1 on February 11, 2014, at 8:35 a.m., on the long hall of Unit two, confirmed the PICC line was flushed with five cc's of normal	F 281	**F 281 Services Provided Meet Professional Standards** The services provided or arranged by facility must meet professional standards of quality. **Residents Affected:** Resident #179 physician orders were immediately reviewed MDS Coordinator regarding PICC line. Licensed nursing staff immediately was in-serviced Staff Development Coordinator regarding following PICC line orders on 2/12/2014. **Residents Potentially Affected:** All residents with IV access devices have the potential to be affected by this cited practice related to administrating the correct dosage of saline via PICC line. 100% of residents with a PICC line were immediately assessed by DON/ADON and orders reviewed to ensure correct dosage were being administered according to the physicians orders. SDC/designee to provide in-service regarding PICC line policy for all licensed nursing staff by 3/16/2014. **Systemic Changes:** The DON/designee will check all new PICC line orders to ensure the correct dosage of saline is administered. The DON/designee will ensure New PICC line orders will be added to the clinical whiteboard process and reviewed each day. **Monitoring Measures:** Any identified concerns related to PICC line physician orders and saline administration will be corrected immediately and reported to the Administrator/DON.	03/16/2014

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F 281	Continued From page 3 saline, and the facility failed to follow the physician's order for resident #179.	F 281	Concerns will be addressed in monthly QA x 3 months for recommendations and further follow-up as indicated.	
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to implement behavior monitoring forms for the months of December 2013, January 2014, and February 2014, for one resident (#34), of three residents reviewed for behaviors, of thirty-six residents reviewed. The findings included: Resident #34 was admitted to the facility on August 3, 2013, with diagnoses which included: Diabetes Type II, Dementia with Behavior, Chronic Kidney disease Stage II, Abdominal Mass Left Upper Quadrant, Alzheimer's Disease, Senile Delusion, Persistent Insomnia and Generalized Anxiety Disorder. Medical record review revealed the resident was prescribed the drug Celexa, used to treat depression, on December 5, 2013 Medical record review of the Behavior/ Intervention Monthly Flow Record dated December 2013, January 2014, and February	F 319	**F319 Mental/Psychosocial Difficulties** Based on a residents comprehensive assessment, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. **Residents Affected:** Resident #34 Behavioral Management Plan and Behavioral monitoring form were assessed immediately. Social Services Director reviewed 2/12/2014 with changes made as indicated. **Residents Potentially Affected:** All residents have the potential to be affected by this cited practice regarding mental/psychosocial difficulties. Social Services/ Behavioral Health Manager will review 100% of all residents Behavioral Management Plans and Behavioral Monitoring Forms for accurate updating of plans by 3/16/2014. **Systemic Changes:** Social Services Director/designee will educate 100% of all nursing staff on Behavioral Management Plans & Behavioral Monitoring Form. The Social Services Director/designee will review 100% of Behavioral	03/16/2014

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F 319	Continued From page 4 2014, revealed the resident was not being monitored for depression. Medical record review of the policy Behavior Management Program dated December 2010, revealed "... The Social Worker, or designee, shall initiate a behavioral assessment and management plan when staff or the MDS process identifies certain behaviors..."and"...Social Worker, or designee, will initiate the Behavior Monitoring Form Psychoactive Medications and place in each Medication MAR (medication administration record)..."and"...The Behavioral Assessment/ Management Plan will be updated on a quarterly basis or after a significant behavioral change...". Interview with Regional Nurse Consultant in copier room next to the Director of Nursing office on February 11, 2014, at 10:48 a.m., confirmed the facility failed to implement behavior monitoring forms for the month of December 2013, January 2014, and February 2014. Interview with Social Services Director in the bridge theater on February 12, 2014, at 11:13 a.m., confirmed the facility failed to implement behavior monitoring form for the month of December 2013, January 2014, and February 2014.	F 319	Management Plans & Behavioral Forms weekly x 4 weeks then 25% monthly x 2 months. Any Concerns will be addressed with the Administrator/DON with Behavioral Management Plans & Behavioral Forms immediately updated. **Monitoring Measures:** All identified concerns related to Behavioral Management Plans & Behavioral Forms will be corrected immediately and reported to the administrator. Concerns will be addressed in monthly QA x 3 months for recommendations and further follow-up as indicated.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each	F 412	**F412 Routine/Emergency Dental Services** The facility services must include dental services that include dental services to meet the need of each residents, provide transportation and must refer residents with lost or damaged dentures to a dentist.	03/16/2014

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F 412	Continued From page 5 resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain routine dental services for one resident (#107) of thirty-six residents observed. The findings included: Resident #107 was admitted to the facility on June 3, 2013, with diagnoses including Hypertension, Anxiety Disorder, and Dementia. Observation and interview with the resident on February 11, 2014, at 10:25 a.m., in the resident room, revealed resident only had three teeth. Continued interview revealed the resident had not had any weight loss and did not have any problem eating. Interview and medical record review on February 12, 2014, at 11:38 a.m., with the Social Services Director and the Director of Nursing (DON), in the DON's office revealed the resident was placed on a list to be seen in March due to requesting dentures. Continued interview at this time with the social services director confirmed the resident was admitted June 2013, and the facility failed to obtain routine dental services.	F 412	**Resident Affected:** Resident #107 is currently scheduled for a dental appointment to be fitted for dentures. **Residents Potentially Affected:** All residents have the potential to be affected by this cited practice related to failure to provide routine dental services. 100% of residents reviewed to ensure dental services are provided. **Systemic Changes:** Social Services Director/designee will interview by 03/16/2014 100% residents to ensure all residents receive dental services as needed. New Dental Services tracking section will be added to the daily clinical whiteboard QA monitoring system. The Social Services Director/designee will review 100% of care plans regarding need for dental services weekly x 4 weeks then 25% x 2 months based on the MDS schedule. Any concerns will be addressed with the DON and corrected immediately. **Monitoring Measures:** Any identified concerns related to routine dental services will be corrected immediately and reported to the Administrator/DON. Dental Services concerns will be addressed in monthly QA x 3 months for recommendations and further follow-up as indicated.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428	**F428 Drug Regimen Review, Report Irregular, Act On**	03/16/2014

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F 428	Continued From page 6 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to promptly notify the physician of pharmacy consultant reports for two residents (#107, #145) of thirty-six residents reviewed. The findings included: Resident #107 was admitted to the facility on June 3, 2013, with diagnoses including Hypertension, Anxiety Disorder, and Dementia. Medical record review of a pharmacy consultation report dated December 2013, revealed, " ...please consider the following trial reduction ...Lorazepam (anxiety medication) 0.5 mg (milligrams) ..." Continued review of the consultation report revealed the physician was notified December 18, 2013, at which time the Lorazepam was reduced. Medical record review of a physician's order and the medication administration record revealed, the medication change was not implemented until December 30, 2013.	F 428	The pharmacist must report any irregularities to the attending physicians, and the director of nursing, and these reports must be acted upon. **Residents Affected:** Resident # 107 MAR reviewed with Pharmacy recommendations immediately corrected on 2/12/2014. Resident # 145 MAR reviewed with Pharmacy recommendations immediately corrected on 2/12/2014. **Residents Potentially Affected:** All the residents have the potential to be affected by this pharmacy consultant and failure to notify physician deficiency. DON/ADON to complete 100% review of all pharmacy consultant reports for February to ensure compliance with recommendations are completed by 03/16/14. **Systemic Changes:** The DON/designee will receive all pharmacy recommendations following consultant visit. The DON/designee will place pharmacy recommendations on clinical white board system for tracking until all recommendations have been completed for the current month. SDC will completed 100% in-service with all licensed nurses regarding notification of physician of the pharmacy recommendations by 03/16/2014. **Monitoring Changes:** The DON/designee will contact physicians immediately regarding any issues with pharmacy recommendations.	

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F 428	Continued From page 7 Interview with the Director of Nursing on February 12, 2014, at 11:24 a.m., in the Director's office revealed the pharmacy consultant made the recommendation on December 5, 2013, and the physician was not notified until December 18, 2013, and the change was not implemented until December 30, 2013, a twenty-five day delay. Continued interview at that time confirmed the facility failed to promptly notify the physician of the pharmacy consultant's recommendation. Resident #145 was admitted to the facility on October 23, 2012, with diagnoses including Alzheimer's Disease, Anxiety Disorder, and Parkinson's Disease. Medical record review of a pharmacy consultation report dated January 2014, revealed, " ...sedating antidepressants ...in an attempt to find the lowest effective dose would it be possible to reduce the dose ...". Continued review of the pharmacy consultation report revealed the physician was notified January 25, 2014. Medical record review of a physician order sheet revealed the antidepressant (Remeron) was reduced at that time. Interview with the Director of Nursing on January 12, 2014, at 11:24 a.m., in the Director's office revealed the pharmacy consultant made the recommendation on January 15, 2014, and the physician was not notified until January 25, 2014, a ten day delay. Continued interview at that time confirmed the facility failed to promptly notify the physician of the pharmacy consultant's recommendation.	F 428	All issues with pharmacy recommendations and notification of physicians will be addressed in the monthly QA x 2 months to confirm that compliance is maintained.	